FAMILY PLANNING IN INDIA

A DESCRIPTIVE ANALYSIS

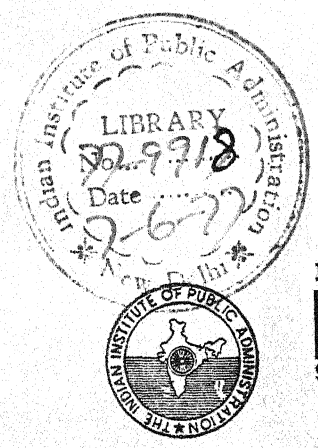
FAMILY PLANNING

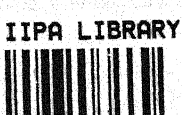
IN

INDIA

(A Descriptive Analysis)

SHANTA KOHLI





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SHANTA KOHLI

FOREWORD

Family Planning Programme was introduced in India in 1952, as an integral part of the socio-economic development of the country. The programme was initiated with a clinical approach where advice was tendered to those who wanted to get the benefit out of it and desired having small families. During the Third Five Year Plan, the extension machinery was widely used to educate the people in the compelling reasons for having small family norms and using various techniques for adoption. A cafeteria approach with the concept of integrated development of health care emerged with the view that development is the best contraceptive for population control. However, the programme got a rude shock recently by the use of coercive methods and lost its credibility. There is an urgent need to evaluate the genesis and reassess the steps taken from the inception and build the undoubtedly inevitable programme of population control on a secure foundation where child care and family welfare become the foci of a new faith in the development of human resources. In this tremendous task peoples' involvement will have to be great indeed. Acceptance of small family norm by couples in the reproductive age will have to come from the *mohallas* and Citizen Committees with the technical help and guidance being made available at grass roots. A social normative power and persuasion alone can now lend credibility to this much maligned programme and give it a new lease of life.

This book analyses the family planning programme from various angles with a view to highlight the current position and indicate future options.

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MARCH, 1977.

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ONE

INTRODUCTION

A. The Problem of Population Growth in India

The growth of population is one of the major problems of our time. India has about 2.4 per cent of the total land area of the world, and has to support about 15 per cent of the world population. The increase in population seriously threatens the achievement of the national objective of ensuring economic and social welfare to the masses. The trends in population growth can be observed from the following table.

TABLE 1.1

TRENDS IN POPULATION IN INDIA (1901-1971)

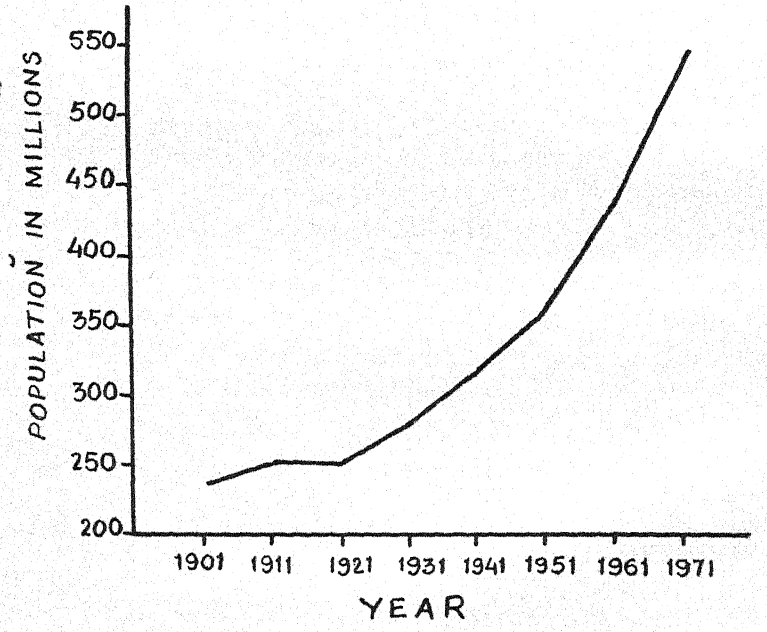
Year	*Total Population (in millions)*	*Density per km*	*%Decade Variation*
1901	238	77	
1911	252	82	+5.73
1921	251	81	—0.30
1931	279	90	+11.00
1941	318	103	+14.23
1951	361	117	+13.31
1961	439	142	+21.64
1971	548	178	+24.80

Source : Pocket Book of Population Statistics, India 1972 : 18-19.

From 1901 to 1951, *i.e.*, within 50 years, there was an increase in population by 123 million. Since 1951 the rate of growth has assumed a quicker pace. Within 20 years it has reached 548 million showing an increase of 187 million. The rate of growth which was 1.1 per cent per annum during 1931 has now reached 2.5 per cent per annum. Today a baby is born

every $1\frac{1}{2}$ seconds. It is estimated that with the present rate of growth India's population will reach 1000 million before the end of the century.

TRENDS IN POPULATION IN INDIA (1901-1971)



B. Factors Associated with Population Growth

The population growth depends upon birth rates, death rates and migration. There is relatively little in or out migration. There is very little scope for migration from India to other countries on an appreciable scale. There are no habitable empty spaces within the geographical confines of India unless the deserts are reclaimed. At present the situation is just the contrary. The deserts are gradually encroaching upon us and making the situation worse. There is traditional immobility which is the outcome of social, economic and religious factors. Migration to another region means unfamiliar life among 'unknown' people who speak different language, eat different

kind of food and have different habits and customs. Internal migration offers no substantial relief from population pressure.

TABLE 1.2

BIRTH RATE, DEATH RATE AND NATURAL GROWTH RATE IN INDIA

Rate per annum per 1,000 population

Year	*Crude Birth Rate*	*Crude Death Rate*	*Natural Growth Rate*
1891-1901	45.8	44.4	1.4
1901-1911	49.2	42.6	6.6
1911-1921	48.1	47.2	0.9
1921-1931	46.4	36.3	10.1
1931-1941	45.2	31.2	14.0
1941-1951	39.9	27.4	12.5
1951-1961	41.7	22.8	18.9
1968	39.0 (Rural)	16.8 (Rural)	22.2 (Rural)
1969	37.6	17.6	20.0
1970	37.0	15.9	21.1
1971	37.2	15.1	22.1

Source : Family Welfare Planning in India, 1972-73 : 99

The rate of growth is not due to any increase in the fertility rate but mainly due to the difference between the birth rate and the death rate. The death rate has fallen from 42.6 per thousand in 1901-1911 to 15.1 in 1971. The expectation of life is increasing steadily (46.5 years in 1969), because of various health measures which have controlled communicable diseases like malaria, smallpox, cholera and other diseases. Due to better health care and maternity and child welfare care the maternal mortality rate and infant mortality rate have also decreased considerably. Deaths from famines have practically been eliminated by relieving local food shortages wherever they occur. Deaths from floods have also gone down because of various flood control measures. As a result of all these measures there has been a continual decline in death rate. It can be safely anticipated that with further expansion of health measures the death rate will come down still further. As the

adoption of a policy to increase mortality is unthinkable, the only way to reduce the rate of population growth is to diminish the stable and high birth rate.

C. Effects of Population Growth on Socio-Economic Development

The country's resources are small to meet the needs of its people. The expectations of the masses are rising. An expanding population further strains the sustenance capacity of an unexpanding land. The rapid rate of growth of population is acting as a great deterrent in the country's effort to raise the standard of living of every citizen through planned development within the framework of a democratic government. Though considerable progress has been made in all fields of development during the successive Five Year Plan periods, the results of the progress have been largely neutralised by excessive growth of population. The present and probable rate of economic growth has little chance of meeting the new burdens.

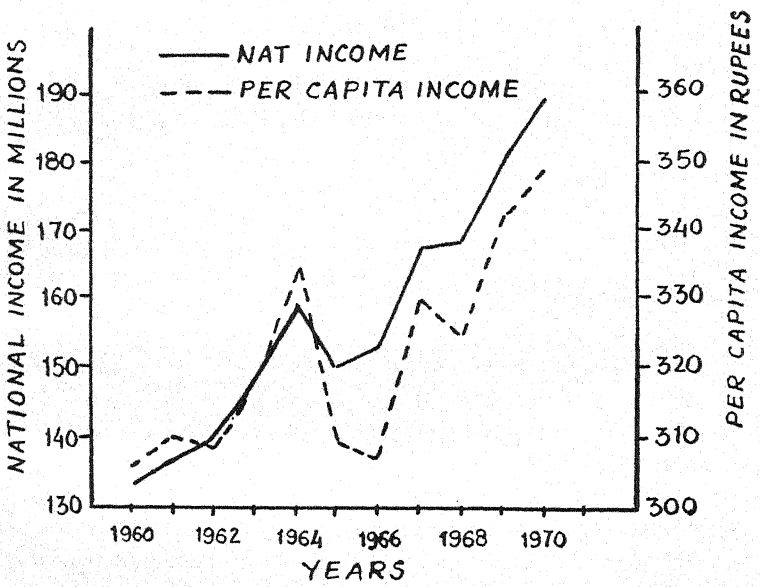
TABLE 1.3

NATIONAL INCOME AND PER CAPITA INCOME AT 1960-61 PRICES

Year	*National Income (Rs. in billions)*	*Per capita income (in Rs.)*
1960-61	132.8	306
1961-62	137.4	310
1962-63	140.1	309
1963-64	147.7	318
1964-65	159.0	335
1965-66	150.3	310
1966-67	152.7	308
1967-68	166.9	330
1968-69	168.2	325
1969-70	180.4	341
1970-71	188.8	349

Source : Country Statement for India—Second Asian Population Conference 1972 : 45.

NATIONAL INCOME AND PER CAPITA INCOME AT 1960-61 PRICES



A large number of children of school age are already out of schools, people whose labour could contribute to the rapid build-up of the economy are out of jobs, per capita food consumption has decreased and in spite of the ambitious housing programme there are still a large number of families without houses. All this is the outcome of the population growth. The growth must be strictly and precisely regulated in accordance with the growth of material resources, primarily agricultural and industrial resources.

TWO

POPULATION POLICY

A. Population Policy in India

The concept of stabilising the population at a level consistent with the requirements of the national economy is not a new idea but in the past the high birth rate was being balanced by equally high death rate. The Government of India appointed the Planning Commission in March 1950. The importance of stabilising the growth of population both in the interest of the family as well as in the interest of the national economy was recognised by the Government of India. A Committee was appointed in April 1951 to report on population growth and family planning by the Planning Commission. This Committee submitted a report to the Planning Commission and in 1952 the Planning Commission recommended that the programme for family limitation and population control should obtain an accurate picture of factors contributing to rapid population increase in India, discover suitable techniques of family planning, devise methods by which the knowledge of these techniques can be widely disseminated and make advice on family planning an integral part of the service of the government hospitals and public health agencies.

Family Planning was started as a Government programme from the first Five Year Plan in 1952. In the first two plans (1951-1961) research projects were initiated and services provided through clinics on a limited scale. There were concerted efforts at educating the public in need of family planning. In 1963 the programme was reorganised and the extension methods adopted. The programme gained momentum in 1966 when it became target oriented and time bound. The present objective of the programme is to bring down the birth rate from 41 to 25 per thousand population, help 120 million couples in the

reproductive age group accepting small family norm and motivate them to actively practise family planning methods.

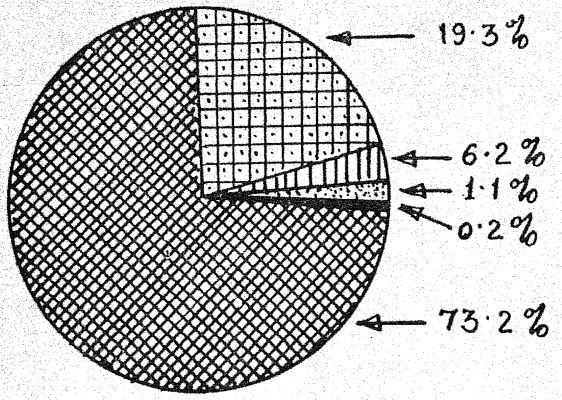
B. The Five-Year Plans and the Family Planning Programme

The Government of India was the first, amongst the few governments in the world to adopt, in 1952, family planning as a national policy and as an integral part of its socio-economic development plans. However, it was restricted to such matters as giving advice on family planning in government hospitals and rural medical centres, conducting field experiments on different methods and collecting information based on scientifically tested experience on the medical, technical and motivational aspects of family planning.

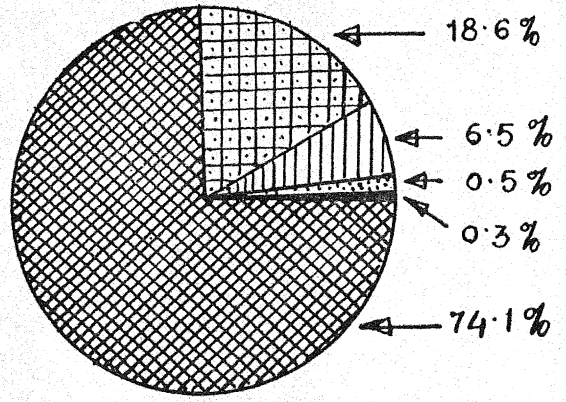
During the first two plan periods the approach was essentially 'clinical'—expecting the people to come for advice and services to the clinics opened under the programme. In the Third Five-Year Plan, the programme was placed on a firmer footing. The narrow 'clinical' approach was replaced by extensive 'community extension' involving intensive education, provision of facilities nearest to homes of the people, advice on the largest possible scale and widespread popular effort in every rural and urban community. In the Fourth Plan, the family planning programme has been included in the highest national priority. It aims at consolidating the structure and components of the programme initiated in the preceding period integrating family planning into maternal and child health care and provides for intensive efforts in such sectors, areas and segments as would be conducive to optimum results.

The 'cafeteria approach' means making available a variety of scientifically proved and tested methods of contraception so that the couples could pick and choose the one best suited to their requirements. Normally the conventional contraceptives (nirodh, diaphragms, jelly / creams and foam tablets) are advocated for newly married couples, while IUD advised for those having one or two children and who want to ensure proper spacing in subsequent births. Sterilisation is recommended

PLANWISE ALLOCATION AND EXPENDITURE ON F.P.



ALLOCATION



EXPENDITURE

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TABLE 2.1

PROGRESS OF FAMILY PLANNING PROGRAMME THROUGH FIVE YEAR PLANS

Plans	*Allocation (in million)*	*Expenditure (in millions)*	*Approach*	*Achievement*
First Plan 1952-56	6.5	1.45	Clinical	(a) Initiation of a demographic as well as medical and biological studies. (b) Orientation training of medical and para-medical personnel in F.P. (c) Printing of educational material
Second Plan 1956-61	49.7	21.6	Clinical	(a) Setting up of a central and state F.P. Boards for giving guidance and laying down policies. (b) Demographic Research Centres. (c) Centres for research in medical and biological aspects of reproduction and population problem. (d) A rural training and demonstration centre. (e) Touring training teams. (f) Development of broad-based training programmes for instructors medical and para-medical personnel. (g) Introduction of sterilisation. (h) Establishment of a well-equipped central organisation.
Third Plan 1961-66	269.8	248.6	Community Extension	(a) Initiation of an extension approach in place of a clinical approach. (b) Communication and Action Research. (c) Broad-based educational programme. (d) Free supply of contraceptive devices like condoms diaphragms, etc. (e) Loop or Intra-Uterine Device (IUD). (f) Regional F.P. Training Centres.
Inter-plan period 1966-69	829.3	704.6	Community Extension	(a) Integration of maternity and child health scheme (MCH) with Family Planning. (b) Emphasis on provision of working and living accommodation for staff in rural areas. (c) Compensation for meeting out of pocket expenses in case of person accepting IUD and sterilisation. (d) Creation of a Central Family Planning corps of doctors. (e) Establish of a factory in public sector for the manufacture of condoms (Nirodh) (f) Transfer of training of Auxiliary Health Nurse, Midwives from Health to F.P.
Fourth Plan 1969-74	3150.0	2802.3	Community Extension	(a) Stress on mass education and use of all contraceptive methods – the 'cafeteria approach'. (b) High priority for construction of buildings for working and living accommodation for medical and paramedical personnel in rural areas. (c) Initiation of the new schemes of : (*i*) Intensive District and Selected Area Schemes, (*ii*) Hospital Post-partum scheme, (*iii*) Immunisation programme, and (*iv*) Prophylaxis against nutritional anaemia.

Source : Family Welfare Planning in India, 1972-73 : 6-8

to those couples who already have two or more children and do not desire to have more.

According to the approach formulated for the *Fifth Five-Year Plan*, the family planning programme will form an integral part of health, maternity and child health and nutrition services. With this change in strategy it is expected that the programme will find a wider acceptance among the people. An outlay of Rs. 5,160 million has been provided for family planning programme in the Fifth Plan.

Between 1951 and 1963 the programme emphasised the importance of establishment of clinics. With the reorganisation of the programme in 1963, use of extension education technique was added to the clinical programme and later on in 1965 the multi-method choice approach was advocated. There have been, therefore, shifts in approaches. Recently the campaign approach is becoming popular. During 1971-72 nine states and fifty two districts were covered by vasectomy camps whereas during 1972-73 the number of states went to sixteen and that of districts to two hundred and ten.

C. Family Planning Methods and Social Schemes

All the recognised contraceptive methods are in use in India. Perspective planning has been done and is reviewed from time to time Annual targets are formulated for IUD insertions and sterilisations and for canvassing additional users of conventional contraceptives. The sterilisation programme was started in 1956 and IUD was introduced in 1965. The IUD programme received a setback in 1966-67 because of complaints about bleeding, pain, and other minor ailments and side effects.

Of the conventional contraceptives, condoms are the most important, and they are widely in demand. Among condoms 'Nirodh' is presently the most popular one. The demand for it is about 95 per cent of the total demand for all conventional contraceptives. The distribution is through (*a*) various family planning centres and subcentres, free of charge, (*b*) depot holders (about 3,300 selected rural post offices get free supply

of Nirodh and the sale proceeds are retained by them as an incentive), and (*c*) commercial distribution schemes.*

The Commercial Distribution Scheme markets through the regular network of salesmen, distributors, wholesalers and retailers of the six distributing companies, namely, Brook Bond, Hindustan Lever, India Tobacco, Lipton, Tata Oil Mills Company, and Union Carbide. The sale is through over 2.2 lakh retail outlets throughout the country. This facilitates people to buy condoms along with their daily needs such as tea and cigarettes.

The All-India Hospital Post-Partum Scheme is a maternity centred hospital-based approach to family planning. It is based on the knowledge that a woman is highly motivated to accept some methods of contraception within the three months following delivery, abortion (post-partum period). Ante-natal and post-natal care to the mothers, their anti-anaemia treatment and their immunisation against tetanus, along with smallpox vaccination, B.C.G. vaccination, D.P.T. immunisation and polio vaccination for children, are rendered under the post-partum programme from 1972-73.

The Intensive District Scheme started its first phase in 1969-70 in seventeen districts of fifteen states. This was an experimental approach to see if intensive work in a particular district was better to get the desired results.

The Selected Area Scheme was started in five area districts of one particular division 'Varanasi' in 1971. This was another experimental approach to see if this particular approach of selecting areas for the intensive work was better to get the desired results.

In a country like India where vast differences are found in different parts of the country, family planning if approached uniformly may not bring desired results in all the places. This is the reason why different schemes are being tried in different places. This will help in evolving a set of best methods for a

*Production of Nirodh in the country has cut down the foreign exchange problem to a great extent as the import of condoms have been restricted.

particular type of place having particular socio-economic set-up.

Mass Education and Media activities are encouraged. Radio, press, field publicity, song and drama, audio-visual aids, films, all are used to educate the mass about family planning. Family planning message through puppet shows is very popular in the rural areas.

With a view to involving "opinion leaders" from all walks of life and make the programme really a peoples' programme, a "direct mail communication project" was also launched in September 1969. By the end of the Fourth Plan, it was proposed to have 2.5 million opinion leaders on the direct mailing list. Suitable audience oriented informational and educational materials are mailed to the opinion leaders all over the country. Support is provided to non-voluntary organisations for stimulating their support to the programme.

THREE

ADMINISTRATION OF FAMILY PLANNING PROGRAMME

A. Organisation of the Family Planning Programme

A Cabinet Committee headed by the Prime Minister meets from time to time to give the programme a proper direction and policy clearance, and to make regular reviews of the progress. Similar Cabinet Committees, headed by the Chief Ministers of the states, exist in most of the states. A central Family Planning Council consisting of all the State Health Ministers and representatives of other organisations connected with family planning work, presided over by the Union Health Minister, reviews the implementation of the programme every six months and lays down broad policies for the centre as well as for the states. Similar councils with appropriate membership exist in almost all the states.

Since April 1966, a separate Department of Family Planning has been constituted at the centre to give proper direction and to effect coordination of the various facets of the family planning programme at the centre as well as the states. This department has a technical wing, headed by the Commissioner of Family Planning, and in this way directs the various technical aspects of the programme. In addition, family planning cells have been created in the health departments of the state governments to give full time attention to this work.

The liaison between the centres and the states is maintained through six regional centres each headed by a regional director. This facilitates day-to-day contacts and constant review of field operations.

In order to involve various departments which have more direct and close touch with the public in the family planning programme at various levels, implementation committees have

been established at the state, district and block levels. They are headed by Chief Secretaries at the state level, District Collectors at the district level and block Development Officers at the block level. Representatives of such departments as Labour, Community Development, Education, Industry and Finance are also associated with them. These committees meet periodically to review the progress of the programme, to remove bottlenecks and to plan the programme for the future.

Voluntary organisations are encouraged to undertake family planning work and are given full financial support. The opinion leaders in villages are given training in specially organised orientation camps. Local bodies and social welfare organisations are also provided with a subsidy to engage in family planning work.

B. The Integration of Family Planning and Health Services

When the programme was launched, at the central level, the Director General of Health Services, who was the Chief Adviser to the Government on all health matters, did not take much responsibility for the family planning programme, except to be present as an adviser at the meetings of the Cabinet Committees and the Central Family Planning Council meetings. The entire health services under him did not, therefore, regard family planning programme as their own programme. The same situation existed in hospitals, dispensaries, medical colleges, wherever there was special family planning staff solely performing such duties. The situation in the states was very much analogous. The programme was, therefore, generally isolated from the rest of the general health services, except when surgical work requiring hospital admissions for camps was involved or when their services were requisitioned. This isolation of the programme from the medical and health services and medical education institutions was one of the reasons for the programme not gaining the required momentum. The Commissioner for Family Planning was not in a position to be in the general stream of the work of the medical and health services to exert sufficient influence on the service and on medical education. One way of remedying this situation was to

designate the Commissioner for Family Planning as Additional Director General of Health Services and Commissioner (F.P.) which could give the necessary influence on the general health services of the country and medical education. A similar change was needed in the states wherever such a situation exists.

The integration of family planning services with the general health services is the corner stone of the Fifth Plan. With the medical base already established, the Government is now in a position to give a more precise direction to the family planning of our services in the light of the future needs and immediate objectives.

The future planning in the medical field can have two main objectives: (*a*) to ensure, concurrently with our efforts to control communicable diseases, a substantial and fairly rapid reduction in the growth rate of population, and (*b*) to provide a base for medical care services which can subsequently transform itself into a National Health Service.

There is no need to make any drastic change in the existing organisational set-up. Creation of an additional cell in the Directorate of Health Services is a potential answer to deal with this scheme exclusively. The setting up of certain committees such as Central Medical Committee, Technical Committee, Zonal Committee and Area Committees may facilitate the functioning. A system of interlocking membership between different committees can be a useful device.

The organisational base should be broad and flexible so as to accommodate changes in objectives and acceptance of additional responsibilities as and when they arise. This plan will bring under one management a large number of services which have remained scattered not by design but for historical reasons.

In Singapore the family planning programme has been integrated with public health services. Similar integration is found in Ceylon and Malaysia. In Taiwan for integration four channels have been utilised :

(1) Action through health bureaux; health stations, and field workers. Thirty county/city-level supervisors will

supervise 450 township-level field workers in the 331 plains area health stations to carry out the field work. About 300 health station doctors are being trained to insert the loop and also to prescribe oral pills and other contraceptives at reduced cost or free. (2) Family planning clinic in 16 provincial hospitals have been set up by May 15, 1969 to serve the public at reduced cost or free. These clinics also serve as centres for training of local health personnel on family planning activities. (3) Loop insertions continue to be made by the 550 private practitioners who have contracted with the Planned Parenthood Association (PPAC) of China at a cost of NT $30. The PPAC also continue to act as distributor of contraceptives. (4) Action also is being taken to educate and persuade members of civil organisations and employees of public and private enterprises to take up family planning. Educational activities also are carried out in all levels of schools, mainly on reproductive physiology and the idea of a small family.*

In Turkey it is reported (Population Council, 1969) that the Family Planning Division of the Ministry of Health will be amalgamated with Maternal and Child Health Division.

It can be hoped that the family planning message could be effectively taken to the masses if it was a 'Peoples Programme' —if it was removed from isolation and taken as part of a total development package. Involvement of people both at the executive as well as the policy level can bring desired results. The integrated approach tends to put democracy to work. It can be hoped that this would result in tremendous release of popular will and energy, which would make any talk regarding constraints on resources meaningless. The system can provide for future adaptability and growth in accordance with changes in the objectives. Willing cooperation of the professional organisations concerned with family planning along with effective participation of the people at various levels of administration can ensure success to the programme.

*Colbourne, M.J., "The Integration of Family Planning and Health Service" to CENTO Conference, February, 1970 : 69.

FOUR

EXPENDITURE ON FAMILY PLANNING

The entire expenditure on family planning is met by the centre while the responsibility for implementation of the programme rests with the states. It was proper not to burden the states with the responsibility of funding resources at least in the initial stages of a national programme so that their energies could be concentrated on implementation of the programme. The expenditure on family planning is part of the plan expenditure and the programme is temporary, though there is a comitment on the part of the centre for the next ten years. The states do not have the financial and administrative flexibility to modify the programme to meet their requirements keeping in view the demographic, social and economic situation in their own states. Whether this is a desired approach is very difficult to answer immediately.

The First Plan included family planning as a welfare programme in the National Development Plan. From Table 2.1 it can be derived that the percentage expenditure had a good increase from plan to plan. In the First Plan only 21.5 per cent of the total allocation was spent, whereas in the fourth Plan it went up to 95.2 per cent.

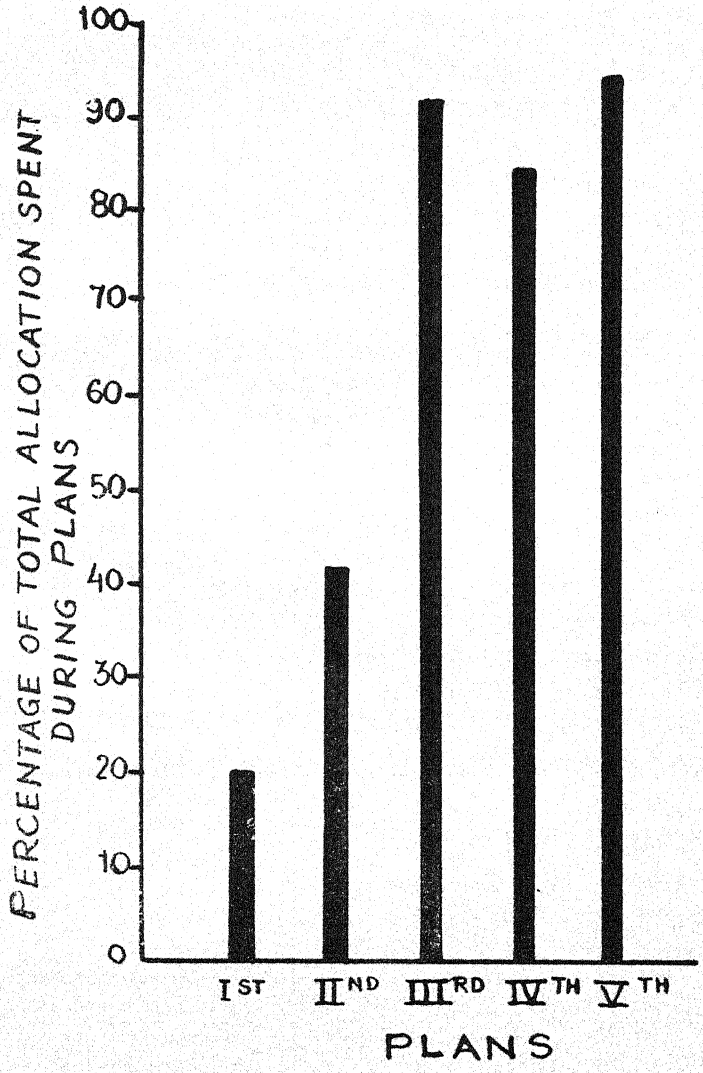
TABLE 4.1

PERCENTAGE OF TOTAL ALLOCATION SPENT ON FAMILY PLANNING PROGRAMMES DURING VARIOUS PLAN PERIODS

Plans	*% spent*
First Plan	21.5
Second Plan	43.5
Third Plan	92.1
Inter Plan Period	85.0 (1966-69)
Fourth Plan	95.2

Source : Percentages worked out from the figures in Table 2.1.

PERCENTAGE SPENT DURING PLANS



The expenditure in the Second Plan was fifteen times more than the tiny amount in the First Plan, but the actual expenditure was not even half of what was allocated for the programme. During the Third Plan the programme took firmer roots and in the Fourth Plan too the same speed was maintained. In the Fifth Plan the allocation is Rs. 5,160 million and it is envisaged that greater progress will be achieved.

By the end of the Third Plan it became clear that the small programme had little impact during its first years of existence and also that the population problem was even more acute than had been recognised earlier. A look at the expenditure figure makes it clear that the Indian Government had made a strong

TABLE 4.2

BREAK-UP OF PLAN ALLOCATION FOR FAMILY PLANNING IN INDIA

Items	*Fourth Plan*		*Fifth Plan*	
	Rs. (in millions)	*% to total*	*Rs. (in millions)*	*% to total*
Service	2448.2	77.7	4225.3	81.9
Training	133.5	4.2	135.3	2.6
Mass Education	150.4	4.9	220.0	4.2
Researeh and Evaluation	92.5	2.9	143.3	2.8
Organisation	55.3	1.8	91.1	1.8
M.C.H.	26.5	0.8	150.0	2.9
Others such as Supply, Maintenance	243.6	7.7	195.0	3.8
Total	3150.0	100.0	5160.0	100.0

Source : Fourth Plan figures from Family Welfare planning in India 1972-73 : 85

Fifth Plan figures from Draft Fifth Plan 1974-79, Vol. II : 253.

and increasing commitment to family planning as an important part of the development process. There has been both a vast expansion in the qualities of resources allocated to the programme and a continuous evolution in the kind of resources which were employed for the programme. But when the picture is visualised in totality we find that during the Third Plan expenditure on family planning was only 0.16 per cent of the total and during the Fourth Plan it was only 1.6 per cent of all Plan expenditure.

From Table 4.2 it becomes clear that the major part of the allocation is for services—about 78 per cent in the Fourth Plan and it is expected to go up to 82 per cent in the Fifth Plan. Whatever little is left from the allocation which itself is quite small has to be distributed intelligently on other items. Educating the mass is one of the major objectives and the amount allocated for it was 5 per cent in the Fourth Plan and is 4 per cent in the Fifth Plan. If methods can be devised to educate people which will not cost much, the picture will not be as gloomy as it looks from the figures. The supply and maintenance should be strengthened because after creating the awareness, if the needs are not met the people will feel more frustrated and disappointed.

The amount of money allocated to support the population policy so far seems to be relatively small. But the problem is so vast that a beginning had to be made somewhere and this beginning which India has made is not a bad one. The allocation of the Fourth Plan was revised during the middle sixties because of difficult conditions which came as a result of the droughts. This show positive efforts on the part of the Government. As it has become an important element of social and economic policy of the Government and as the programme does not believe in coercion or compulsison the radical changes are difficult to be perceived but it can be assumed that long-term education and motivation of the people on a sustained basis are sure to bring positive results for this national programme. To bring change in the beliefs and attitudes of the masses and to change their behaviour is a task which needs patient but persistent efforts.

FIVE

EVALUATION OF THE FAMILY PLANNING PROGRAMMES

A. Family Planning Performance Statistics

In the programme of family planning, the stage has come where there is need to take stock of the achievements and limitations, review the strategy, and evolve new ways to give the programme a greater push and drive in order to achieve the objectives. And for this purpose it is necessary to go into detailed statistics about the performance of family planning programmes.

The spectrum of available methods includes the loop (IUD) insertions, sterilisation (both male and female), foam tablets, jellies and diaphragms. The oral pill is in a pilot demonstration stage and its further extension will depend upon evaluation of the results of the project.

Among the conventional contraceptives, the use of 'Nirodh' (condoms) has been gaining in popularity. Besides the free distribution through the family planning clinics, Nirodh is being made available through the commercial outlets and through the depot holders. The excellent progress which this scheme has made during the past five years can be seen from Table 5.1.

Market research carried out independently by Operations Research Group, Baroda has shown that consumer purchase of Nirodh is growing more rapidly in medium/smaller town and rural areas than in cities thereby achieving one of the main objectives of this programme. This can be seen from the Table 5.2.

Nirodh is promoted through publicity campaigns, utilising press, radio, cinema, outdoor displays and printed materials.

TABLE 5.1

ANNUAL SALE OF "NIRODH" (CONDOMS) AND THE INDEX OF PROGRESS IN INDIA

Year	*Nirodh Sales (in million pieces)*	*Index of Progress 1968-69=100*
1968-69	15.74	100
1969-70	29.59	188
1970-71	52.71	335
1971-72	66.55*	423
1972-73	77.68*	500

* There was stock shortage from November 1971 to November 1972 which affected the sales in these two years.

Source : Family Welfare Planning in India 1972-73 : 88

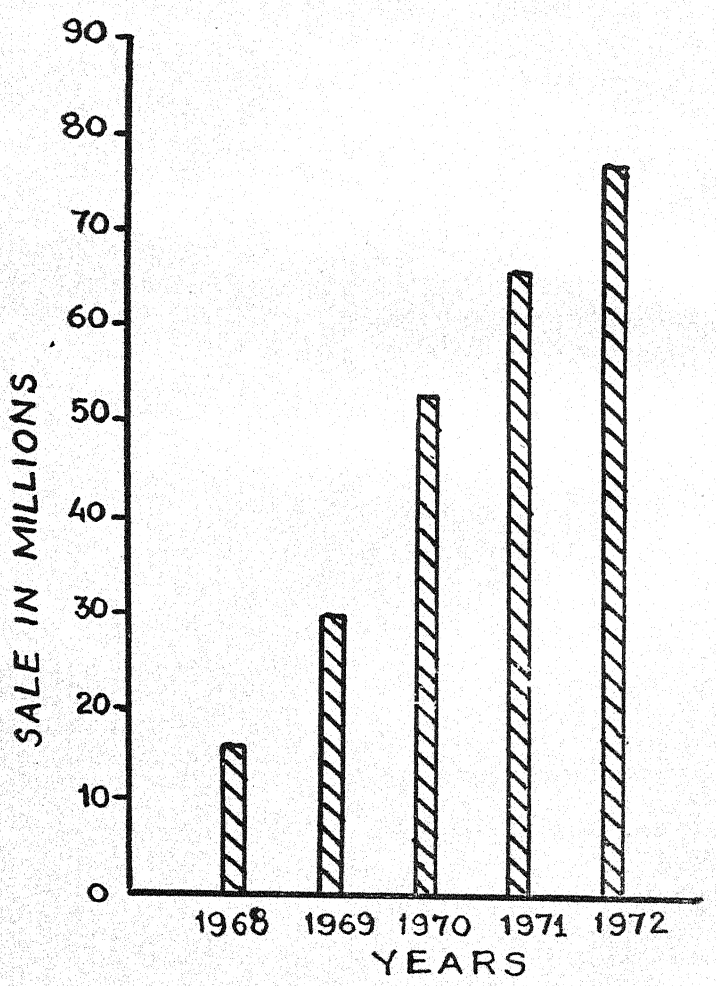
TABLE 5.2

ESTIMATED CONSUMER PURCHASE OF "NIRODH" BY AREA OF DIFFERENT POPULATION SIZE DURING 1970 AND 1973

Classification of Area	*Estimated Consumer Purchase (in million pieces)*		
	Jan. 1970	*Jan. 1973*	±%
Cities with 100,000+ Population	1.66	2.65	+60
Medium towns with 20,000 to 100,000 population	0.61	2.46	+303
Small towns below 20,000 population	0.35	0.67	+91
Rural areas	0.104	1.400	+1246

Source : Family Welfare Planning in India 1972-73 : 89

YEARWISE SALE OF NIRODH



Nirodh retailers are also being supplied through the companies, publicity materials for display purposes.

There have been significant achievements in terms of setting up the infrastructure, making supplies and services available, mass extension and motivational efforts. In respect of conventional contraceptives, periodic shortages in supply contributed to shortfall in performance sometimes.

In taking Method as a base of performance for family planning programme, one can obtain figures in terms of sterilisation, IUD insertions, conventional contraceptive users which gives two types of picture : one is that of the total acceptors and the other is that of the equivalent sterilisations (calculation by adding the number of sterilisations, one-third of IUD insertions and one-twelfth of conventional contraceptive users).

Sterilisation was introduced during the Second Plan, conventional contraceptives in 1963 and IUD in 1965. The following table gives the number of acceptors and their total according to different methods and number of equivalent sterilisation for All-India over different Plan periods.

TABLE 5.3

NUMBER OF ACCEPTORS AND THEIR TOTAL BY DIFFERENT METHODS AND NUMBER OF EQUIVALENT STERILISATIONS OVER DIFFERENT PLAN PERIODS (ALL INDIA)

(*Figures in millions*)

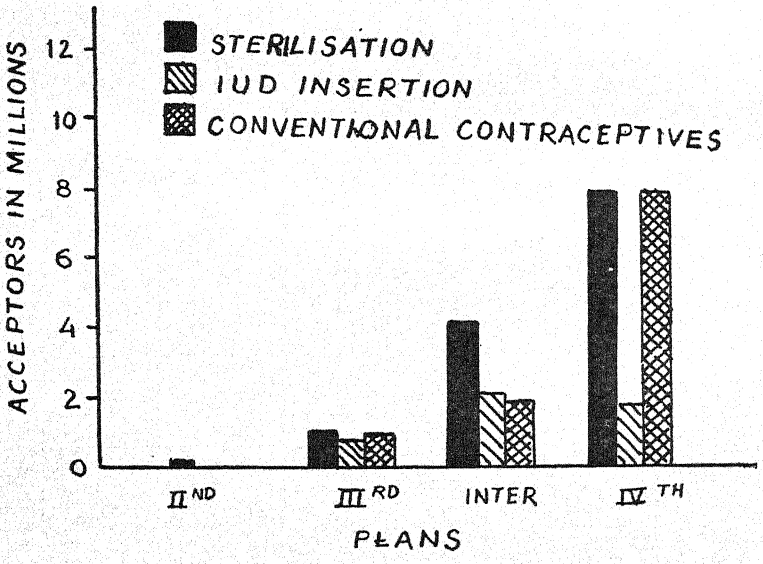
Plans	*Sterilisations*	*IUD Insertions*	*Conventional Contraceptives*	*Total Acceptors*	*Equivalent Sterilisation*
2nd	0.2	0.0	0.0	0.2	0.2
3rd	1.4	0.8	1.3	3.5	1.8
Inter-plan 1966-69	4.4	2.1	1.9	8.4	5.2
4th 'til 1973	8.1	1.8	8.1	18.0	9.3

Source : Figures are worked out from the table D.1 from Family Welfare Planning in India 1972-73, Ministry of Health and Family Planning, Department of Family Planning, New Delhi, p. 41.

More than nine million people have undergone sterilisation or equivalent sterilisation. This number is equal to, or perhaps more than, the total sterilisation in the rest of the world. Statistics in other fields such as conventional contraceptives also indicate an impressive record. At the same time, it is undeniable that the number of total acceptors of family planning

is not rising at the rate at which it ought to be, if the birth rate has to be brought down to 25 per thousand within a reasonable period of time. Either we seem to be too ambitious in our target setting or we are set struggling hard to achieve the set targets.

TOTAL ACCEPTORS BY DIFFERENT METHODS OVER PLANS



For all the methods targets were set so that it could give a guideline for the implementors of the programme. The total picture for this can be derived from Table 5.4.

The figures for percentage of achievements of targets show that for sterilisation the Fourth Plan shows a decline and for IUD a rise when compared with figures for Inter-Plan period. But when the achievement figures are taken into account, the Fourth Plan figures are definitely better than the Inter-Plan period as far as sterilisation is concerned. The total number of IUD insertions was definitely less during the Fourth Plan when compared with that of the Inter-Plan period figures. For the conventional contraceptives the achievement figures and percentage of achievements of targets both were high. The

TABLE 5.4

TARGETS, ACHIEVEMENTS AND PERCENTAGE OF ACHIEVEMENTS OF TARGETS IN STERILISATIONS, IUD INSERTIONS AND CONVENTIONAL CONTRACEPTIVES AND THEIR TOTAL OVER FOURTH AND INTER PLANS IN INDIA

(*Figures in millions*)

	Sterilisation			*IUD Insertion*			*Conven. Contra.*			*Total*		
Plans	*T.A.*	*Ach.*	*%*	*T.A.*	*Ach.*	*%*	*T.A.*	*Ach.*	*%*	*T.A.*	*Ach.*	*%*
Inter-Plan (1966-1969)	4.9	4.4	89.8	6.9	2.1	30.4	6.5	1.9	29.2	18.3	8.4	45.9
4th Plan ('til 1973)	12.6	8.0	63.5	3.3	1.8	54.5	15.3	38.1	52.9	31.2	17.9	57.3

Source : Figures worked out from the table D.4 from Family Welfare Planning in India 1972-73, Ministry of Health and Family Planning, Department of Family Planning, New Delhi, p. 44.

similar picture emerges for total numbers where all the methods are taken together. All this shows that there has been significant achievements as far as the programme is concerned.

The total number of rural sterilisations went up during the Fourth Plan period but the percentage of rural to total sterilisations came down by about 2 per cent. This was because the urban sterilisations also went up during the Fourth Plan. The total rural IUD insertions came down during the Fourth Plan but the percentage of rural to total IUD insertions went up slightly. This was because the urban IUD insertions also came down during the Fourth Plan. The rural performance is higher than the urban performance. This probably is due to more publicity and efforts taken in the rural areas. When this is taken together with what Operations Research Group of Baroda has shown

TABLE 5.5

ALL INDIA RURAL-URBAN BREAKDOWN OF STERILISATION AND IUD INSERTIONS DURING THE INTER PLAN PERIOD AND FOURTH PLAN PERIOD

(*Figures in millions*)

Year	Sterilisation			% of Rural to Total	IUD Insertions			% of Rural to Total
	Rural	Urban	Total		Rural	Urban	Total	
Inter-Plan 1966-1969	2.71	1.67	4.38	61.9	1.22	0.83	2.05	59.5
Fourth Plan ('til 1972)	2.97	1.97	4.94	60.1	0.86	0.57	1.43	60.1

Source: Figures worked out from the tables D.4 and D.5 from Family Welfare Planning in India 1972-73, Ministry of Health and Family Planning, Department of Family Planning, New Delhi, pp. 45-46.

about consumer purchase of Nirodh (Table 5.2), it seems the programme is not in a bad situation as far as its objective of involving more and more rural population is concerned. The downward trend for IUD insertions can be attributed to the shortage of lady doctors, lacks of staff mobility and reluctance of the acceptors engendered by possibilities of complications such as bleeding, pain and other minor ailments.

Total number of vasectomy and tubectomy both have an upward trend when the Plans are compared. But when the percentages to the total sterilisations are compared it becomes clear that the number of vasectomy operations are having a greater rise than the number of tubectomy operations. The Fourth Plan figures show a slight variation but this may be because the available figures are only up to 1973. This trend

TABLE 5.6

BREAKDOWN OF STERILISATION INTO VASECTOMY AND TUBECTOMY AND THEIR PERCENTAGE TO TOTAL STERILISATION DURING DIFFERENT PLANS (ALL INDIA)

(*Figures in millions*)

Plans	Total Sterilisation	Vasectomy		Tubectomy	
		Total No. of Vasectomy	% of vas. to total Sterilisation	Total No. of Tubectomy	% of Tubectomy to total Sterilisation
2nd	0.15	0.07	46.5	0.08	53.5
3rd	1.37	1.07	77.8	0.30	22.2
Inter-Plan (1966-1969)	4.39	3.81	86.9	0.58	13.1
4th ('til 1973)	8.06	6.17	76.5	1.89	23.5

Source : Figures worked out from the table D.2 from Family Welfare Planning in India 1972-73, Ministry of Health and Family Planning, Department of Family Planning, New Delhi, p. 42.

is welcome because vasectomy operations are much cheaper than the tubectomy operations and they do not need hospitalisation as required in the case of tubectomy operations.

In All-India the trend seems to be positive towards family planning although the progress does not seem to be complying with the target set. The figures of acceptance in different states bring it out very clearly that there are some states which can be called progressive states as far as the family planning results are concerned. Their achievements are encouraging and sometimes they show higher performance than the general

TABLE 5.7

RATE PER THOUSAND POPULATION FOR STERILISATION AND IUD INSERTIONS UP TO MARCH 1973 IN DIFFERENT STATES

No.	State	*Sterilisation*		*IUD insertions*	
		Cumulative Total (in millions)	*Rate per 1000 pop.*	*Cumulative total (in millions)*	*Rate per 1000 pop.*
1.	Andhra Pradesh	1.53	34.2	.19	4.2
2.	Assam	.18	11.7	.14	9.0
3.	Bihar	.90	15.5	.27	4.7
4.	Gujarat	.91	32.9	.19	7.0
5.	Haryana	.21	20.6	.28	26.9
6.	Himachal Pradesh	.05	15.4	.05	13.1
7.	Jammu & Kashmir	.07	14.2	.06	11.7
8.	Kerala	.66	30.1	.26	11.7
9.	Madhya Pradesh	1.12	25 8	.29	6.8
10.	Maharashtra	.41	46.3	.35	6.7
11.	Mysore	.61	20.3	.27	9.0
12.	Orissa	.68	30.2	.28	12 5
13.	Punjab	.31	22.4	.48	34.2
14.	Rajasthan	.31	11.4	.15	5.5
15.	Tamil Nadu	1.53	36.0	.20	4 8
16.	Uttar Pradesh	1.20	13.2	.68	7.5
17.	West Bengal	.94	20.4	.32	7.0
18.	Manipur	.03	2.4	.01	9.1
19.	Tripura	.02	10.7	.02	1.3
	All India Total including Union Territories	13.97	24.7	4.65	8.2

Source : Figures taken from tables D.7 and D.8 from Family Welfare Planning in India 1972-73, Ministry of Health and Family Planning, Department of Family Planning, New Delhi, p. 56 & 58.

About eight states have higher per thousand coverage for sterilisation and nine states for IUD insertions when compared with All-India figures. Kerala and Orissa have higher figures for both sterilisation and IUD insertions. Andhra Pradesh, Gujarat, Maharashtra, Tamil Nadu, Haryana, and Punjab are some of the states whose results are encouraging. Tripura, Manipur, Bihar and Rajasthan need greater efforts if the desired goals are to be reached. In a country like India regional differences cannot be avoided The total picture must be taken along with the regional picture so as to get the true feeling of the existing programme and its efforts. More research is needed to find out the exact reasons for higher performance in certain states. At present one can only have hunches which must be proved by facts and figures.

B. Impact of Family Planning Programme

Many authorities concerned with the evaluation of the Indian family planning programme or with family planning programmes in general, have pointed out that the conclusion that are reached depend very much upon the perspective from which one views the programme. An overview can have several alternative approaches. Economists or the economic planners try to evaluate the programme from the point of view of its contribution to planned development; the administrators take 'reduction in the birth rate' as the yardstick for assessing the programme and the effectiveness they try to assess in terms of 'operational goals' such as group acceptance, knowledge about the programme and availability of the supplies. Success rates are measured by such indicators as the percentage of the population who are using family planning methods and accept the 'small family norm'. These 'operational goals' are not complete in themselves. The goal of reducing the birth rate along with the 'operational goals' must be related to the larger development goals in order to get a complete picture of the programme. Change in the birth rate is the most important indicator. It has close connection with the economic benefits generated by the programme. The behavioural change too ultimately reflects in the number of births prevented. Thus the number of births prevented is the final measure of output of the

programme and this must be taken along with the cost factor which is very important for assessing the efficiency of any programme.

TABLE 5.8

NUMBER AND PERCENTAGES OF COUPLES IN THE REPRODUCTIVE AGE GROUP CURRENTLY PROTECTED DUE TO VARIOUS METHODS OF FAMILY PLANNING IN INDIA

Year	*Estimated couples in reproductive age group (in millions)*	*Percentage of couples currently protected due to :*			
		Sterilisation	*IUD*	*Conventional Contraceptive Use*	*Total*
1966-67	90.03	2.4	1.5	0.5	4.4
1967-68	92.26	4.2	1.7	0.5	6.4
1968-69	94.55	5.6	1.6	1.0	8.2
1969-70	96.90	6.6	1.6	1.6	9.8
1970-71	99.31	7.4	1.6	2.0	11.0
1971-72*	101.55	9.4	1.5	2.3	12.9
1972-73*	102.34	11.3	1.4	2.3	15.0

*Provisional

Source : Figures taken from Family Welfare Planning In India, 1972-73 : 67.

The above table shows a clear steady increase for all the methods except IUD where the pattern is towards decline. As IUD remains an excellent method for spacing children, particularly in the low parity groups, the causes for decline should be looked into very well and better devices need to be developed. The total coverage for all the methods is very small—only 15 per cent but there has been a steady increase from year to year which seems to be a good sign.

The state-wise distribution of reproductive age group couples currently protected shows that for sterilisation only 25 per cent of states are above the All-India average, for IUD about 37.5 per cent, for conventional contraceptives about 15.6 per cent and for all the methods taken together about 34.4 per cent are above the All-India average. Punjab is the only

TABLE 5.9

NUMBERS AND PERCENTAGES OF COUPLES IN THE REPRODUCTIVE AGE GROUP CURRENTLY PROTECTED DUE TO VARIOUS METHODS OF FAMILY PLANNING DIFFERENT STATES UP TO MARCH 1973

No.	State	Estimated No. of couples in the reproductive age group	Percentage of couples currently protected due to :			
			Sterilisation	IUD	Conventional Contraceptive	Total
1.	Andhra Pradesh	8.4	15.4	0.6	0.6	16.6
2.	Assam	2.4	6.5	1.3	0.2	8.1
3.	Bihar	11.4	6.7	0.9	0.1	7.8
4.	Gujarat	4.9	25.5	0.9	1.5	17.9
5.	Haryana	1.6	11.0	4.7	4.7	20.4
6.	Himachal Pradesh	0.6	5.9	1.8	0.5	8.2
7.	Jammu & Kashmir	0.9	5.4	2.0	0.2	7.6
8.	Kerala	3.2	16.4	2.5	0.3	19.2
9.	Madhya Pradesh	8.4	11.2	1.4	0.9	13.5
10	Maharashtra	9.6	21.3	0.6	1.5	23.4
11.	Mysore	5.2	9.8	1.2	0.6	11.6
12	Orissa	4.3	13.0	2.9	1.3	17.2
13.	Punjab	2.3	11.5	6.0	7.3	24.8
14.	Rajasthan	5.0	5.0	1.1	0.7	6.8
15.	Tamil Nadu	7.6	15.9	1.2	0.6	17.7
16.	Uttar Pradesh	17.1	5.9	1.4	0.4	7.7
17.	West Bengal	7.6	10.2	0.7	0.7	11.6
18.	Manipur	0.2	1.3	2.4	0.2	3.9
19.	Tripura	0.3	5.0	0.2	0.7	5.9
All India		102.3	11.3	1.4	2.3	15.0

Source : Family Welfare Planning in India Year Book 1972-73 : 65-66.

state which has higher figures than All-India for all the methods separately as well as for all the methods together. This makes it clear that care must be exercised in the evaluation of the total Indian programme because of the differences among states. The diversity of achievement by states if studied in greater detail might throw light regarding some of the new approaches which could be more helpful in bringing the desired results. The success rate of methods are different for different states and this gives a clue as to which method should be encouraged in which state.

TABLE 5.10

NUMBER OF BIRTHS AVERTED DUE TO VARIOUS METHODS OF FAMILY PLANNING IN INDIA SINCE 1971

(*Figures in millions*)

Years	*Births averted due to*				*Cumulative Total*
	Steri-lisation	*IUD*	*Conventional Contraceptive*	*Total*	
1961-62	.1	—	—	.1	.1
1963-64	.2	—	—	.2	.3
1965-66	.5	.1	.1	.7	1.0
1967 68	1.3	.8	.2	2.3	3.3
1969-70	2.7	1.0	.4	4.1	7.4
1971-72	3.9	1.0	.6	5.5	12.9

Source: Figures worked out from the table E.3 from Family Welfare Planning in India, 1972-73, Ministry of Health and Family Planning, Department of Family Planning, New Delhi, p. 68.

The number of total births averted during 1961-62 was .1 million whereas the cumulative total reached 12.9 million in 1972-73. It can be estimated that since the inception of the programme, if the progress can be maintained at the same pace a total of 40 million births will be eventually averted by 1994-95. If the progress can be enhanced the number can be raised even further. The overall impact of this is going to be much more impressive because each birth if not averted would have left a certain impact on the population growth of the country.

Although the immediate effects do not seem very impressive the long-term effects cannot be overlooked.

George B. Simmons makes a very interesting analysis of the impact of family planning programme. He translates the statistics concerning the number of sterilisations and IUD insertions into the number of births prevented. He takes help from 'alternative fertility' and calculates each insertion to prevent 0.54 births and each sterilisation to prevent 2.3 births.[1]

Simmons works out cost benefit analysis of the family planning programme and comes to the conclusion that each sterilisation is worth Rs. 11,562 and each IUD insertion worth Rs. 3,243.[2] Average expenditure per equivalent sterilisation has been worked out to be Rs. 190.37 in 1969-70 and Rs. 203.56 in 1972-73. Total number of equivalent sterilisations were 1.7 million in 1969-70 and 3.4 in 1972-73.[3] The interpretation of benefits accruing as the result of births prevented can be a good indicator of positive impact of family planning programme in India. Simmon's interpretation of benefits is given in Table 5.11.

The Benefit/Expenditure which was .0 in 1956-57 slowly rose to about 1 in 1960-61 and about 2 in 1964-65. It had a slight setback during 1965-66 but ever since had a steady rise. The figures for 1971-72 show again a slight fall but it is not alarming. It may be because the Family Planning inputs and outputs do not occur simultaneously. There may be a delay between expenditure undertaken on family planning and the desired economic effect. Most of the benefits resulting from the activities of the Indian Family Planning Programme are delayed.

For India to achieve its family planning targets nearly all fecund couples where the wife is 25 years or older would

[1]Simmons, G. B., "The Indian Investment in Family Planning" an Occasional Paper of the Population Council, New York, 1971; 59 and 66.

[2]Ibid.

[3]Family Welfare Planning in India 1972-73 : 86

TABLE 5.11

BENEFITS ACCRUING IN A YEAR AS THE RESULT OF BIRTH PREVENTION (1956-57 to 1972-73)

Year	*Benefits*	*Expenditure*	*Benefits/ Expenditure*
1956-57	.0	1.74	.0
1957-58	.0	4.91	.0
1958-59	1.94	5.63	.34
1959-60	6.66	8.79	.76
1960-61	16.26	16.68	.97
1961-62	33.65	23.22	1.45
1962-63	62.96	44.71	1.41
1963-64	111.09	33.94	3.27
1964-65	184.25	90.60	2.03
1965-66	286.75	151.90	1.89
1966-67	439.69	152.05	2.89
1967-68	745.61	265.30	2.81
1968-69	1254.58	324.08	3.87
1969-70	2096.11	406.80	5.15
1970-71	3180.98	489.04	6.50
1971-72	4431.10	617 55	7.18
1972-73	5487.24	797.43	6.88

Source: Family Welfare Planning in India, 1972-73 : 84.

have to accept family planning. If the programme is to make a significant inroad in this huge number of eligible couples, the number of acceptors should be much larger than it has been during the past years.

The impact of the family planning programme is rather diffused and this makes it very difficult to have some dramatically obvious impact. But nonetheless, it is very difficult to deny the fact that the family planning programme is proving itself beneficial—beneficial for the Government and beneficial for the people. The programme statistics regarding family planning programme strengthen this point. By taking an angular view and criticizing the programme will not be fair. It is always good to have an overall view and then assess the programme in its totality.

SIX

RECOMMENDATIONS

1. The family planning programme is isolated from the rest of the general health services, except when surgical work requiring hospital admissions for camps is involved or when their services are requisitioned. This isolation of the programme from the medical and health services and medical education institution is one of the reasons for the programme not gaining the required momentum. Integration of family planning with general health services is a must if the desired results are to be obtained.

2. If the programme is to make a significant impact so as to achieve the birth reduction to 25 per thousand, nearly all fecund couples where the wife is 25 or older would have to accept family planning. Greater efforts are required for larger coverage.

3. The non-attainment of the stipulated reduction in the birth rate may be because of the highly ambitious targets set. To reduce the disappointments and frustration it is necessary that the approach and the targets should be more realistic.

4. The IUD was introduced in 1965. The programme received a setback in 1966-67 because of complaints about bleeding, pain and other minor ailments. As this remains an excellent method for spacing children, particularly in the low parity groups, research is needed to remove its various deficiencies and to evolve, if possible, a better device.

5. There should be concentration of efforts on couples with higher parity for their acceptance of the terminal contraceptive method and for IUD the focus should be the young married woman with one or two children.

6. The conventional contraceptives need little change. The greater emphasis should be placed on female-oriented

methods where women will have greater freedom and opportunity to decide when and how many children they would like to bear.

7. In order to get the people out of the legacy of large family norms and clannish loyalties, a deliberate efforts has to be made to get the whole social value system changed. Institutional services like baby sitting, creche, etc., must be tackled either by the family planning department or by some other department with the cooperation of the family planning department. The usefulness of the small family in poverty reduction must be propagated through various mass medias using plain and meaningful words.

8. Acceptance of and living according to small family norms requires a comprehensive scheme of social security and family welfare planning.

9. High fertility seems to have a direct correlation with low productivity. If we are able to raise the productivity of the people we may be successful in reducing the reproduction rate.

10. The attainment of national goal of population control through reduction of the national birth rate will have to wait until the attainment of personal goals such as approprite health, education, employment, social security and social welfare are met fully.

11. The regional differences in performance brings out clearly the need for research to find out the causes of success in certain states and failures in some other states. This would help selection of the right approach.

SEVEN

CONCLUSION

The Indian family planning programme is one of the many programmes for economic and social development that have been introduced by the Government of India in the hope of improving the condition of the masses. At the present stage of high birth rate and comparatively low death rate, it is necessary to accelerate the process of reduction of the birth rate through massive family planning efforts. Although the need for such efforts were recognised since the First Five Year Plan and efforts made with the introduction of family planning programme in 1952, the real vigorous implementation started only with the Third Five Year Plan when the approach was shifted from clinical to extension education. The programme implies bringing about change in attitudes and behaviour. Its guiding principles are to convince individuals that the change is in their personal interest and it is socially accepted and desirable. It depends on long-term education and motivation of the people on a sustained basis and the programme envisages that the community must be prepared to feel the need for the services. Greater efforts are needed to bring changes in the attitude of the masses.

Population control is a national goal—as a means to social, cultural and economic prosperity but it is presented in terms of individual health and welfare—as a personal goal. This may lead to dichotomies in concepts, methods and organisation, etc. The effort on the part of the Government for the removal of dichotomies has found an answer in the 'cafeteria approach' making available a variety of scientifically proved and tested methods of contraception so that the couples could pick and choose the one best suited to their requirements.

The Medical Termination of Pregnancy Act, 1971 came into force with effect from 1st April 1972. Its administration and

implementation is monitored by the Depatment of Health and it is going to benefit the family planning programme in an indirect way.

There are still gaps in the infrastructure, which need to be filled expeditiously. There is need for a continuing review of the programme and exploration of new approaches so that the message of family planning can be taken to a hundred million couples spread over hundreds and thousands of villages and towns in a most efficient way. It has to become a people's movement.

The family planning programme is now reaching a massive audience, but it has become somewhat combersome. There is a vast army of employees presently working for the programme at different levels of administration. The massive dimensions of the family planning effort and the inherent complexity of the task present an enormous challenge to the Public Health Administration. If it has to succeed in accomplishing its goals, the programme must improve its administration and control mechanism.

During the Fourth Five Year Plan the aim was to reduce the birth rate from 39 per thousand to about 32 per thousand population. The birth rate in 1975 at the beginning of the Fifth Five Year Plan is about 35 per thousand population—three points shorter than what was envisaged. Under such circumstances it does not seem possible to bring the birth rate down to 25 by the end of 1980-81. The Fifth Five Year Plan appears to be more realistic because it envisages birth reduction by five points by the end of the Plan and reaching the point to 25 per thousand population by 1983-84. To reach this level a much higher level of performance on a continuing basis throughout the Plan period is required. The approach which is going to be taken during the Fifth Five Year Plan is an approach where the family planning programme will form an integral part of health, maternity and child health and nutrition services. With this change in strategy it is expected that the programme will find a wider acceptance among the people because the guarantee of nutrition and health and the guarantee of livelihood may be the two best guarantees for the quick

success of family planning changes in the strategies may be required from time to time and if the family planning programme is open to this, better success is certainly ensured.

The perspective of family planning should include measures for the total welfare of the family which would comprise spacing, treatment of infertility, marriage guidance or marriage counselling, family life education and child care.

Changing fertility behaviour is a complex process. This must be dealt with in the broad perspective of social and economic changes and must have a multi-factoral approach. A number of steps must be taken which cumulatively will bring about a favourable climate in which family planning programme can change from surviving stage to flourishing stage.

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